McCook Clinic, P.C.

Authorization to Use or Disclose Protected Health Information

Patient Name: ____________________________________ Date of Birth: _______________________

(Previous/Maiden Name, if applicable): ____

I authorize the disclosure and use of my protected health information generated by McCook Clinic, PC to the individual(s) listed on this form.

Authorized Individuals:	
Name:	**Name:**
Address:	**Address:**
City/State/Zip:	**City/State/Zip:**
Phone #:	**Phone #:**
Email:	**Email:**

Name:	**Name:**
Address:	**Address:**
City/State/Zip:	**City/State/Zip:**
Phone #:	**Phone #:**
Email:	**Email:**

SENSITIVE INFORMATION: I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. ________ (initial)

Reason for this Authorization:	☐ Continuity of care to include medical information, appointments & testing results

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ___________________________________. If I fail to specify an expiration date, event or condition, this authorization will remain in effect until further notice.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact (Nichole Hartzer, RHIT, HIM Director/Privacy Officer, or Brian Rokusek, Office Manager/Security Officer).

____
(Signature of Patient)

____
(Signature of parent, guardian, or authorized representative)

____
(Date)

____
(Relationship to Patient)

Initials of Staff Preparing Authorization: _________